The ABCs of MSAs and FCEs

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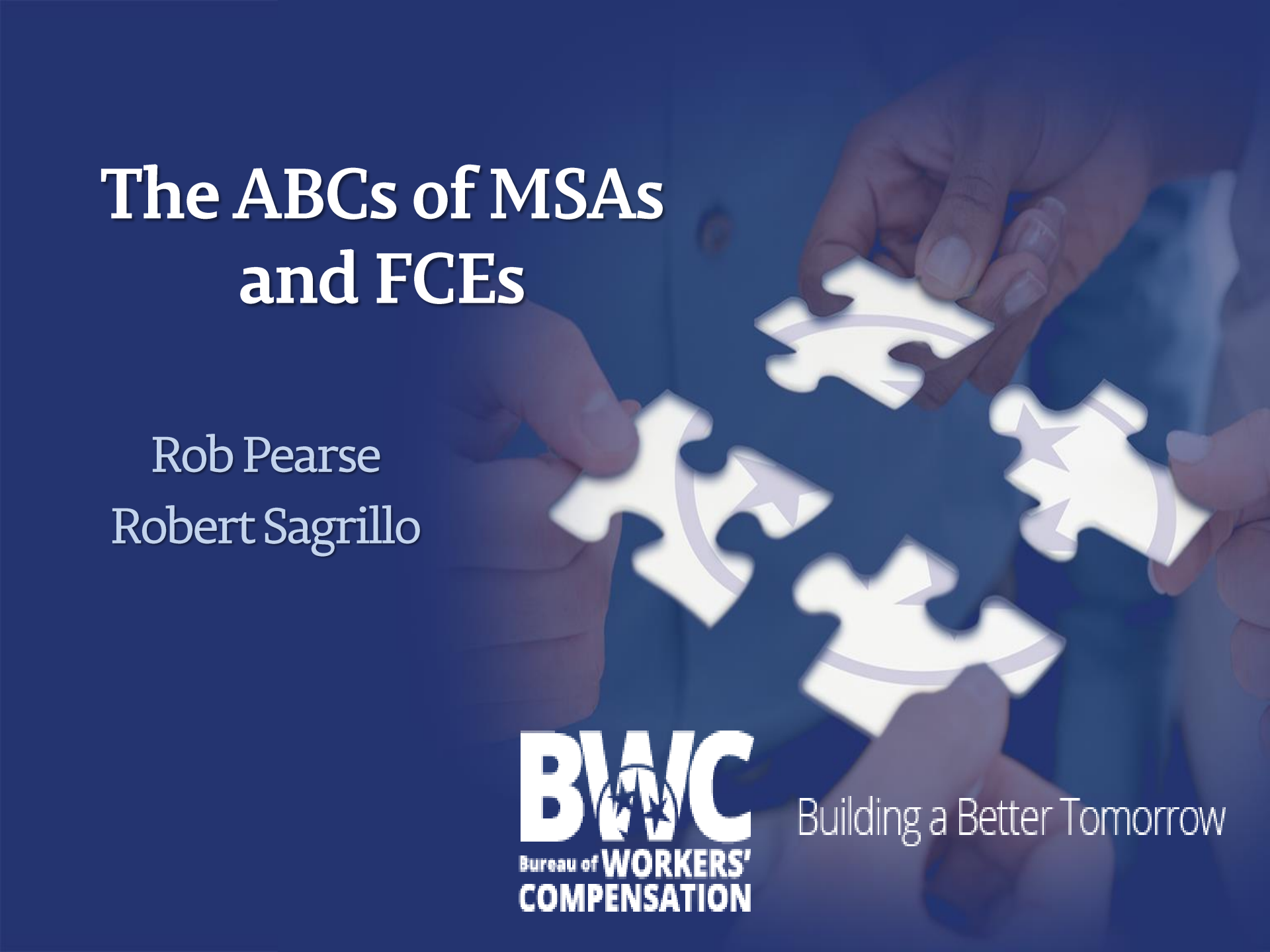

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Building a Better Tomorrow

MEDICARE SET-ASIDES: TO SUBMIT OR NOT

CMS WCMSA APPROVAL AND THE ALTERNATIVES

Presented by: Robert L Sagrillo JD LLM

Medicare Set-Asides are a Legal Fiction

- No Law Requires an MSA
  - Statute
  - Regulation
  - Memos

- Tool to Avoid Burden Shift
  - Mid 1990's, multimillion dollar catastrophic claims
  - 2001 CMS memo changed landscape

- Changing climate
  - Increased MSA amounts
  - Increased time
  - No assurances, CMS unpredictable

Medicare Set-Asides are a Legal Fiction

- More attention to alternatives
- Evidence-Based Medicine and Non-Submit Programs increasing in WC area
- National Alliance for Medicare Set-Aside Professionals Annual Conference topics for past several years

Types of MSAs

- Commutation: fully funds future injury-related Medicare-covered treatment
- Compromise: apportions the future medical in a net settlement based on the relative value of the various damage elements asserted in the claim.
- Partial Waiver: fully funds the future injury-related Medicare-covered treatment for the accepted conditions and seeks a waiver from CMS for the denied conditions.
- Zero Dollar MSA / Total Waiver
- Nuisance Value
- Evidence-Based Medicine, Standards of Care MSA (hold harmless/indemnification protection)

Submission or Non-Submission ?

- **CMS Review is Voluntary in Nature**

Section 8.0 of the WCMSA Reference Guide, March 19, 2018:

"There are no statutory or regulatory provisions requiring that you submit a WCMSA amount proposal to CMS for review. If you choose to use CMS' WCMSA review process, the Agency requires that you comply with CMS' established policies and procedures in order to obtain approval."

Section 4.2 of the WCMSA Reference Guide, March 19, 2018:

" Submitting a WCMSA proposed amount for review is never required. But WC claimants must always protect Medicare's interests."

CMS WCMSA Workload Review Thresholds

For Medicare Beneficiaries

The claimant is a Medicare beneficiary at the time of the settlement and the total settlement amount is greater than $25,000.

For Non-Medicare Beneficiaries

The claimant is not a Medicare beneficiary at the time of the settlement, but the total settlement amount is greater than $250,000 AND the claimant has a reasonable expectation of Medicare enrollment within 30 months of the settlement date.

CMS WCMSA Review Thresholds

Total Settlement amount includes (but is not limited to):

- Wages, attorney fees, all future medical expenses
- Any previously settled portion of the WC claim
- The total payout should be used if an annuity is used to fund any of the above— not the cost or present value of the annuity
- Repayment of any Medicare conditional payments

CMS Submission Process

WCMSA Reference Guide (updated July 10, 2017)

Documents needed for submission

- ✓ Cover letter
- ✓ Consent to Release
- ✓ Rated Ages with specific statement
- ✓ Life Care/Future Treatment Plan
- ✓ Settlement Agreement/Proposed Order (or statement that there are none)
- ✓ WCMSA Administration Agreement (or info regarding type of admin)
- ✓ Medical Records
- ✓ Payment History
- ✓ Supplemental or Additional Information

Documentation and Development Letters

- Form is important for these documents
  - Inconsistency regarding acceptable formatting

- Development letters
  - BCRC or WCRC determines they need additional information before review
    - 30% of all submissions end up with one or more
    - May seek inappropriate information, ie reserve details

- Section 16.1 WCMSA Reference Guide – case closed for more than one year from original submission, need to restart submission process

Determinations

- May approve the amount submitted or “counter”
- Determination based on CMS guidelines is generally overfunded and unlikely to exhaust
- Rationale often analyzes information incorrectly

EXAMPLE:

“ The CMS position is not whether a carrier demonstrates liability, but whether Medicare would reasonably pay for something in the future that should have been covered as it related to the WC claim.”

Determinations cont.

- Medicare **ONLY** becomes primary when you have accepted finalized determination and have proper exhaustion and accounting of the MSA

  - Doesn't matter if you have funded the CMS determination, if claimant doesn't administer the funds correctly, Medicare won't become primary until the amount of mismanaged funds are returned to the MSA account.

Alternatives to Traditional MSA

- Do nothing
- Non-submission of traditional MSA following CMS standards
- Evidence based medicine/standards of care allocation
- Compromise allocation

Do Nothing

- General release, no allocation
- Section 111
- Burden on claimant
- Possible action to set-aside settlement
- Joint and several liability for conditional payments
- Private cause of action?

Non-Submission of Traditional MSA

- Expedient
- Overfunded allocation
- No protection from future CMS actions

EBM/Standard of Care Allocation

- Standards of Care/Evidence Based Medicine vs. CMS Methodology, 35-50% savings
- MSA is based on the probable versus the possible
- Medically and legally defensible
- Increases the ability to settle the medical portion of the claim

Compromise

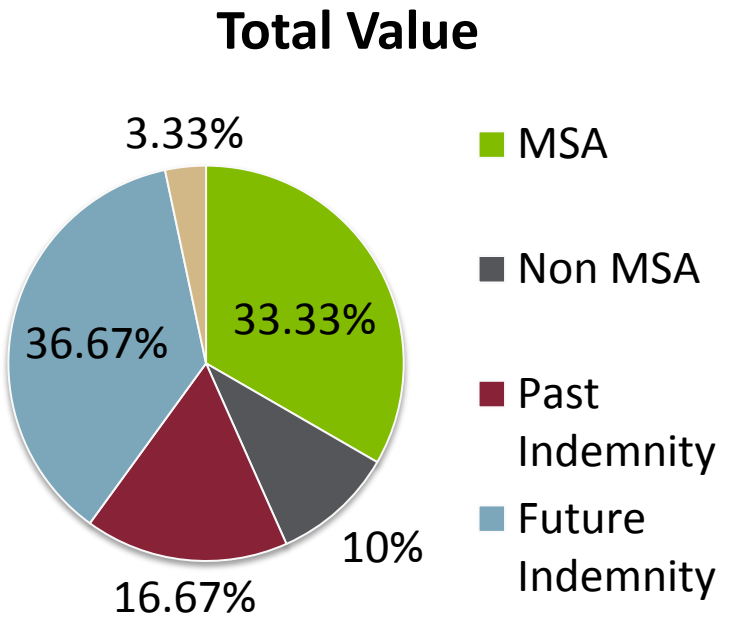
- Allows for reasonable consideration of Medicare's interests while taking into account the disputed nature of certain claims
- 42 CFR 411.46 and 411.47
- SSR 70-38
- Looks to the ratio between:
  - The full possible indemnity and non-Medicare covered exposure (i.e. – full amount claimant would get if defense lost the case) AND
  - The MSA (which includes both accepted and disputed)
- Compromises allow you to settle your case for whatever you can settle it for, the MSA is then 'fit into' the settlement

Compromise – Creating the Percent

Example:

MSA amount: $50,000

Non-Medicare covered medical: $15,000
Past Indemnity Exposure: $25,000
Future Indemnity Exposure: $55,000
Liens: $5,000
TOTAL EXPOSURE: $150,000



Ratio of MSA to the TOTAL EXPOSURE: $50,000 / $150,000

Percentage: 33.33%

Compromise – How to Apply

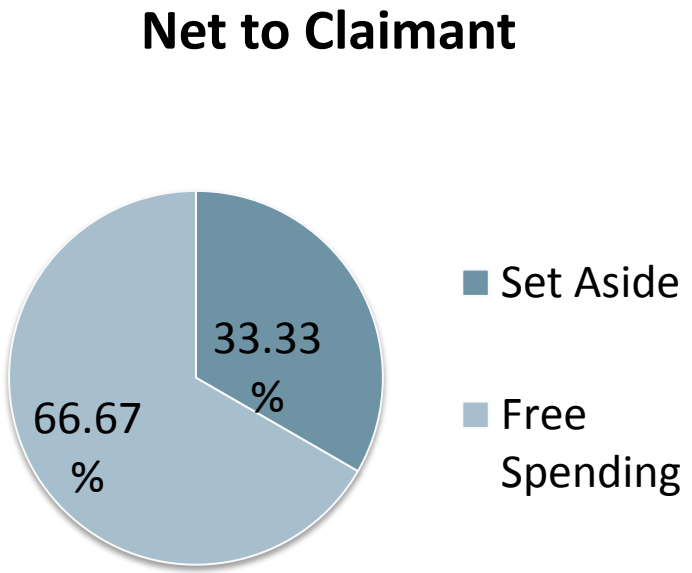
Percentage is applied to the NET of the Claimant

Case settles for $40,000

- Attorney fee is 20%: $8,000
- Lien: $5,000

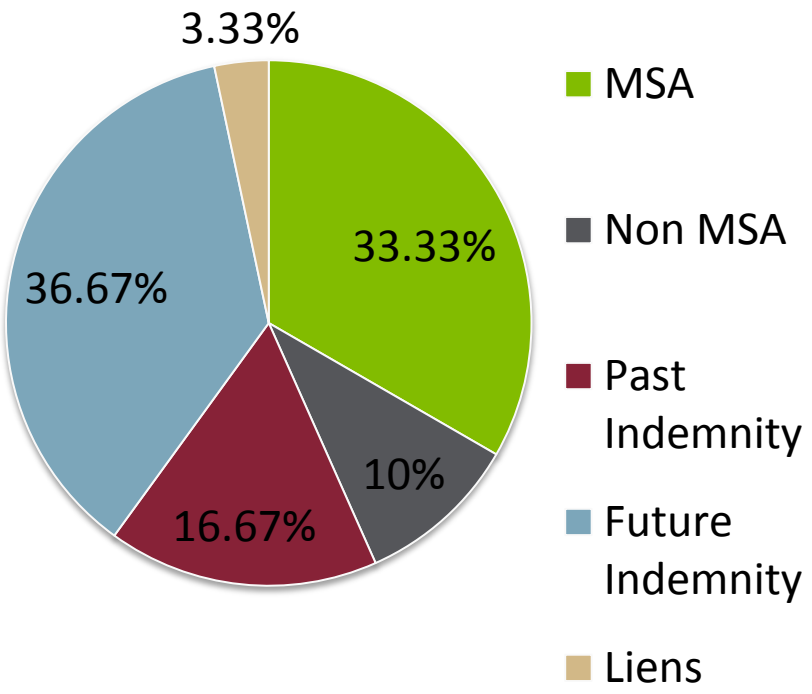
= $27,000 NET to Claimant

33.33% of $27,000 or: **$8,999.10**

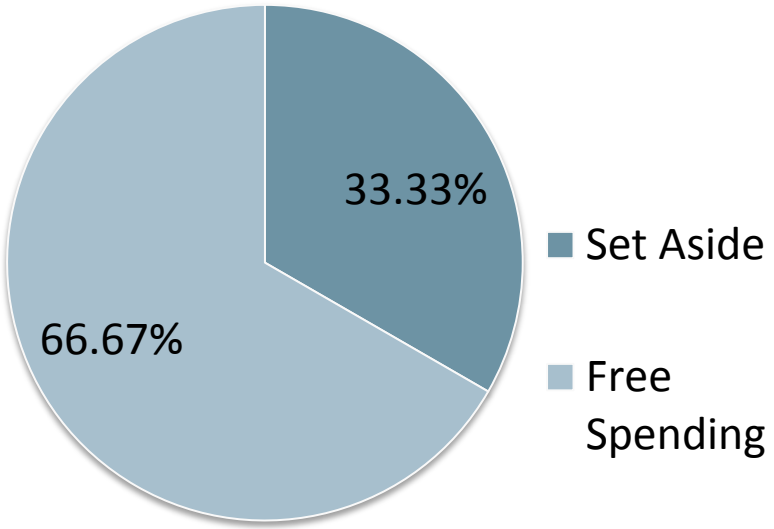


Comparison

Total Value



Net to Claimant



Other Considerations

- Administration
- Who bears the risk
- Legal basis
- Documentation
- Insurance
- Hold Harmless and Indemnification

Thank you for your time and attention

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FCE's: The Good The Bad The Ugly

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FUNCTIONAL CAPACITY EVALUATIONS (FCE)

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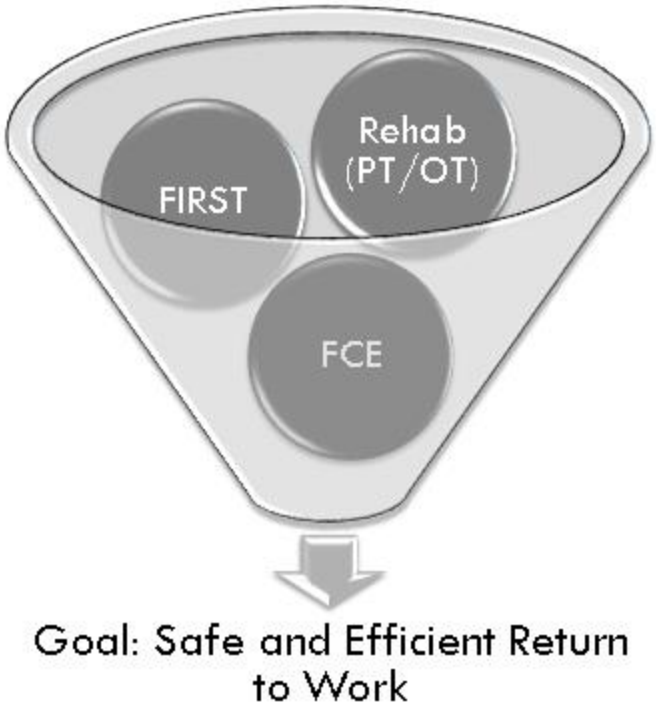
ATI Workers' Compensation Services



- Rehabilitation: PT/OT (Hand Therapy)
- F.I.R.S.T. (Functional Integration of Rehabilitative & Strength Training) = Work Conditioning/Work Hardening
- **Functional Capacity Evaluations (FCE)**

Our comprehensive services meet the needs of the injured worker from beginning to end

Defining an FCE

- Functional Capacity Evaluation
- Series of tests, set up in such a way to determine the individual's functional capabilities at that point in time
- Designed to "assess" not to educate, treat, or diagnose
- A legally defensible document assessing an individual's functional capabilities at that point in time. It provides information on:
  - Reliability/Consistency of Effort
  - Activity tolerances
  - Physical Demand Level (PDL)
  - Appropriate Recommendations specific to the injury/diagnosis and occupation

When is an FCE Appropriate?

FCE provides an opportunity for **case closure**:

- At completion of all treatment and MMI is reached
- To determine RTW status and if restrictions are needed
- To determine validity of effort/reliability of complaints
- Upon request: MD, NCM, Attorney, ADJ, Employer

Different FCE Testing "Systems"

Matheson

Isernhagen

Key

Workwell

Blankenship

BTE

ARCON

FCE Evaluator Credentialing

Physical Therapist (can be good, but can also be bad due to subjective impressions and wanting to diagnose)

Occupational Therapist (can be good, sometimes bad)

MS Certified/Licensed Athletic Trainer (better chance of being good with focus on objectivity and not subjective opinions)

MS Exercise Physiologist/Kinesiologist (better chance of being good)

<u>This can be debated with reasonable arguments supporting each professional designation</u>

Why the ARCON or BTE Method for FCE's?

- Data collection is through computer interface (allows for force-time curves, peak force, average force, trends with curves)
- Not manual force-load cells, Jamar hand dynamometer, or manual heart rate collection
- Enhanced objective data collection and not relying on subjectivity
- Actual test protocols for positional tolerance activities (Methods Time Measurement) that is objective and not subjective based on observations and educated guessing
- Physical demands are classified as Occasional, Frequent, or Constant abilities with objective criteria to confirm abilities
- Better defensibility

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Benefits of the ARCON or BTE Method

- Standardized Protocols
- Consistency/Reliability of Effort Determination (COV, REG, HR, IHSC)
- Objective testing not influenced by subjective complaints
- Continuous Heart Rate Monitoring
- Predictable and Defensible
- Report presentation
- Digital pictures

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How does ARCON and BTE determine RELIABILITY of effort?

- Wireless Heart Rate Monitoring
- Hand Dynamometer/Grip Strength/Rapid Exchange
- Static Strength testing/repeated testing (COV)/horizontal strength changes
- Continuous Heart rate monitoring with all testing
- Observations or motion discrepancies confirmed with digital pictures included in report
- Behavioral discrepancies in relation to pain complaints

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FCE EDUCATIONAL TRAINING

Equipment Manufacturer Certification

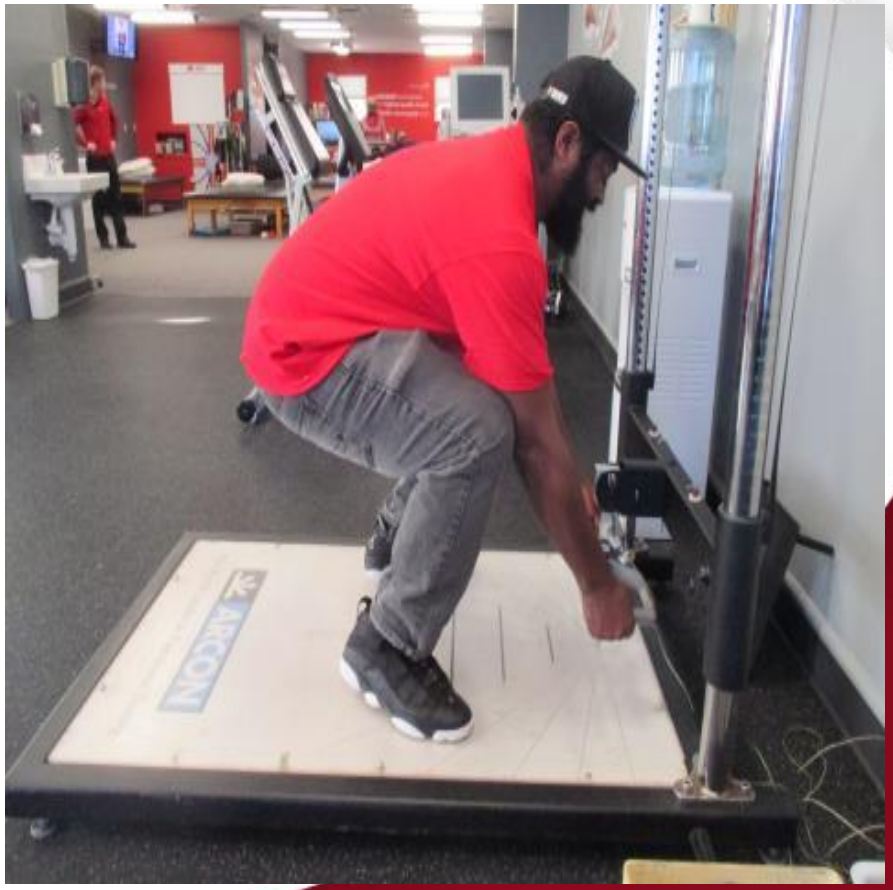
(most companies offer this)

VS.

Non-Specific FCE Educational Training

(unbiased towards any specific company)

STATIC STRENGTH TESTING
Floor Lift vs H Floor Lift



STATIC STRENGTH TESTING
Torso Lift vs H Torso Lift

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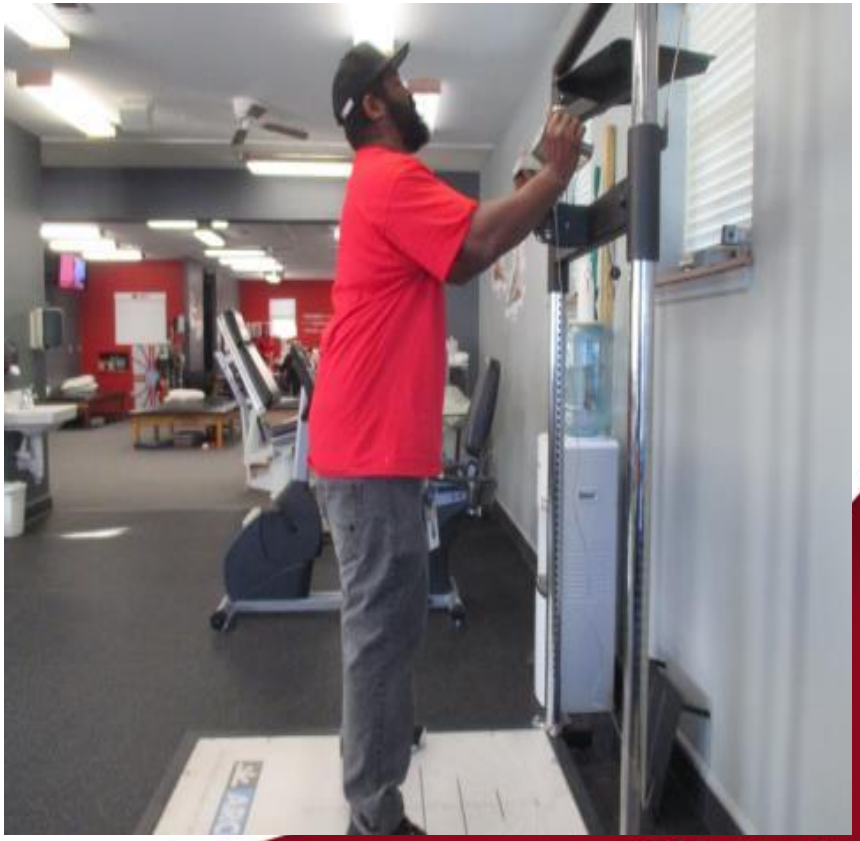
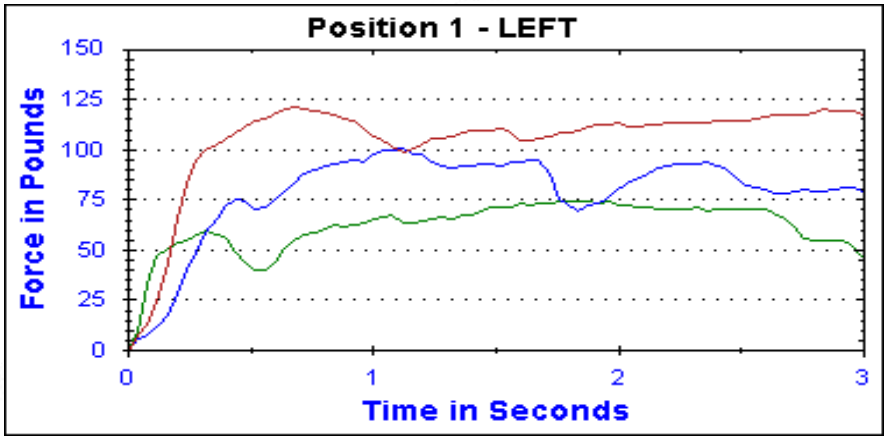
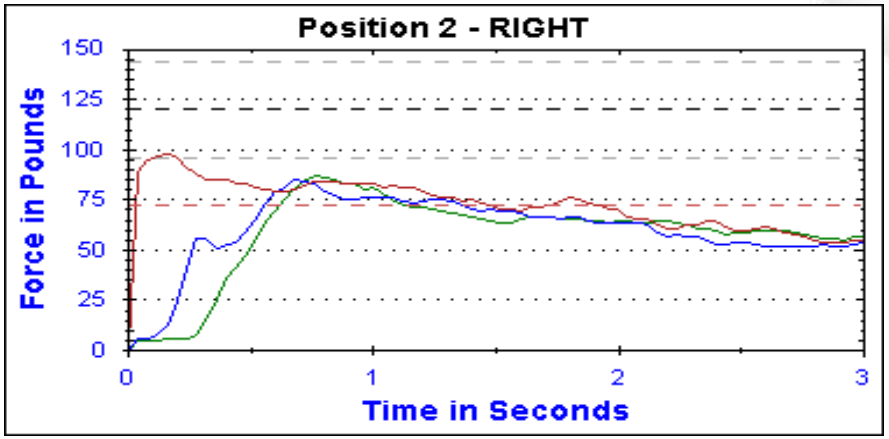
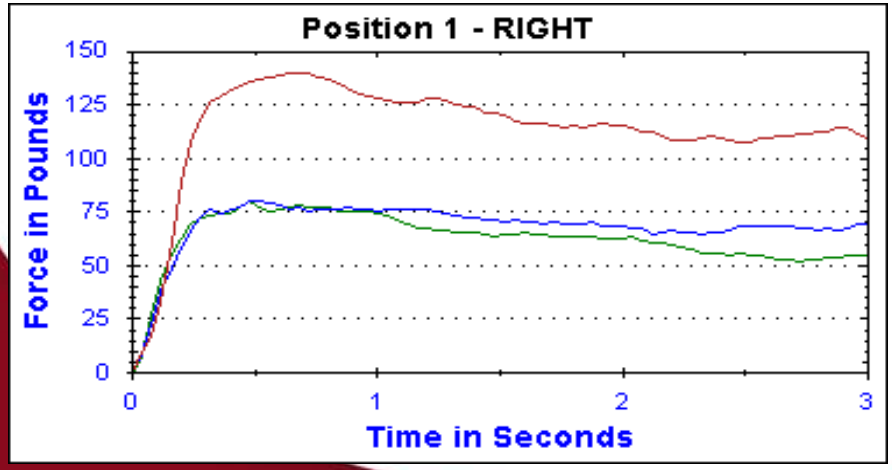
STATIC STRENGTH TESTING
High Near Lift vs H High Near Lift

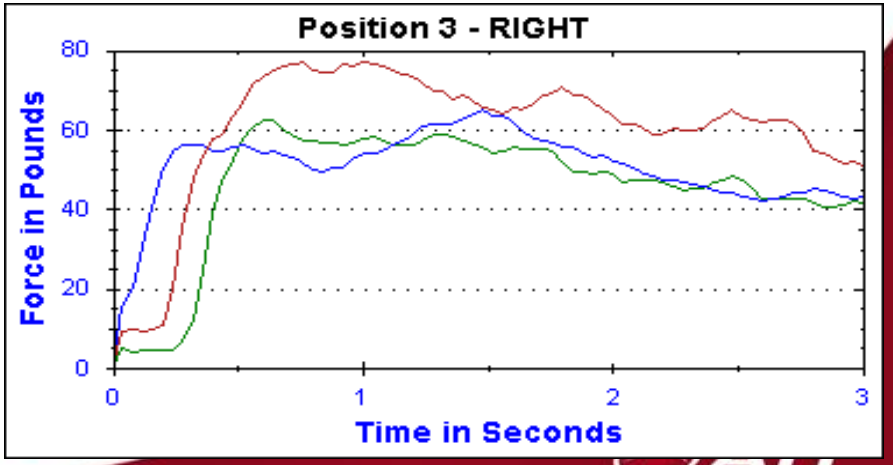


GRIP STRENGTH
Force-Time Curves

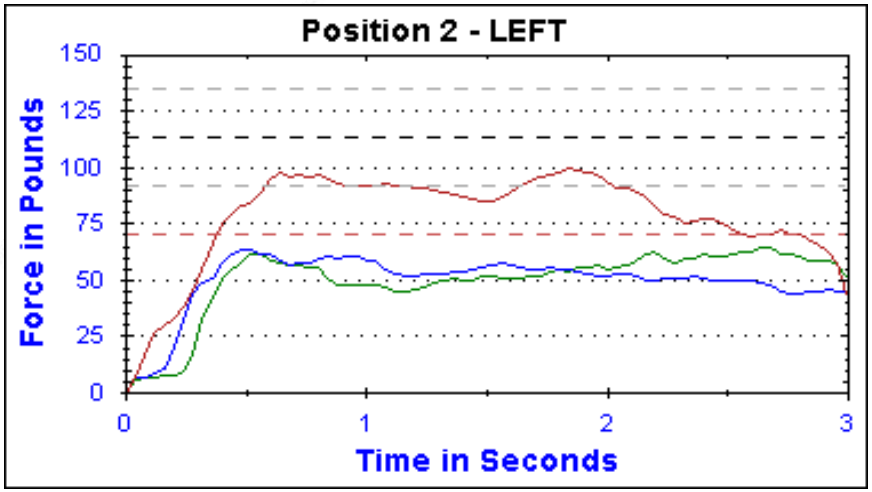


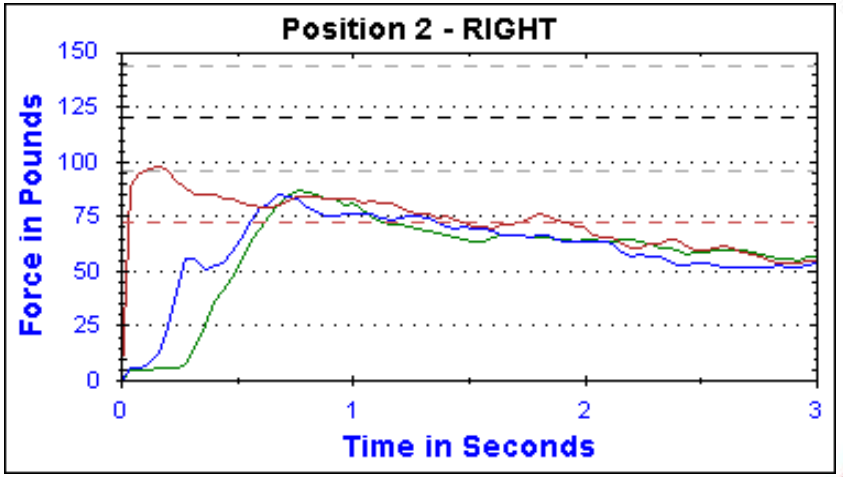


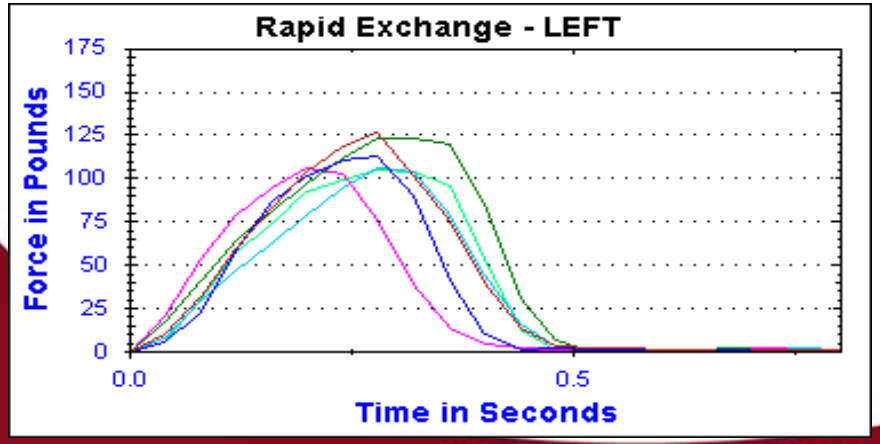


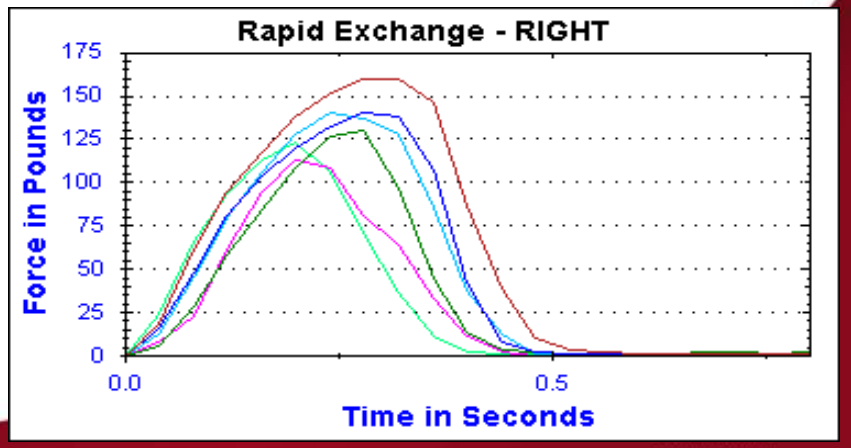


GRIP STRENGTH
Rapid Exchange vs Maximal Effort









Questions an FCE can answer

- Are the demonstrated results of physical testing reliable/consistent? If not, what are examples of inconsistencies?
- Is the client capable of performing their regular job duties?

  If not, what are the restrictions related to the injury?
- What are the demonstrated tolerances, measures of function as defined in Dept. of Labor terminology or compared to a formal job description?

The Good, The Bad, The Ugly

GOOD FCE's – determine consistency of effort and reliability of results; if consistent, compare to physical demands of job at the time of injury or alternative job being offered; if job demands are not met, recommend appropriate restrictions related to injury and specific job. Reliability can be verified objectively. FCE report is clear and concise to all parties involved.

BAD FCE's – have minimal consistency measurements (grip strength is commonly the only objective consistency measurement to confirm reliability of effort and results). Do not compare to specific job demands of job duties at time of injury, or alternate jobs being offered. Reliability of results cannot be verified objectively. FCE report may be difficult to read and interpret.

UGLY FCE's – no objective consistency measurements to verify level of effort; physical abilities rely on subjective complaints from patient; report is very difficulty to read and decipher; recommendations are not specific to injury being evaluated (i.e.. UE restrictions for LE injury).

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Thank you!

Questions and Discussion